



## **GRACE SWIMMING CLUB**

Buchanan Street Rothwell QLD 4022

Postal Address: PO Box 3121 Clontarf DC 4019

Phone: 07) 3204 – 2725 FAX: 07) 3204 - 2189

### **CONFIDENTIAL MEDICAL FORM**

(Please note there are two pages to this form)

SWIMMERS SURNAME .....

GIVEN NAMES .....

DATE OF BIRTH ..... RELIGION .....

HOME ADDRESS .....

HOME TELEPHONE ..... MOBILE .....

SCHOOL .....

SWIMMER LIVES WITH: MOTHER FATHER BOTH PARENTS GUARDIAN  
(Please circle)

GUARDIAN/MOTHERS FULL NAME .....

GUARDIAN/FATHERS FULL NAME .....

WORK TELEPHONE .....

**EMERGENCY CONTACT** (Neighbour, Aunt/Uncle, Grandparents)  
(It is vital that you give us an Emergency Contact other than Parents)

NAME ..... REALATIONSHIP .....

ADDRESS .....

TELEPHONE .....

DOCTOR ..... MEDICARE NO. ....

ADDRESS .....

TELEPHONE .....

**PLEASE GIVE DETAILS OF THE FOLLOWING:**

HEARING PROBLEMS .....

VISUAL PROBLEMS .....

HEART PROBLEMS .....

RESPIRATORY PROBLEMS (eg. Asthma) .....

ALLERGIES .....

TRAVEL SICKNESS .....

PHOBIAS .....

OPERATIONS .....

RECENT ILLNESS .....

MEDICATION REQUIRED .....

DRUG REACTIONS/ALLERGIES (eg. Penicillin) .....

.....

CURRENT TETANUS DATE .....

OTHER INFORMATION .....

N.B In the event of serious accident requiring urgent professional treatment, do you agree to the child being taken to the nearest medical aid for treatment eg. Hospital?  
**YES / NO** (please circle)

DO YOU KNOW OF ANY ALLERGIC REACTION YOUR CHILD HAS TO ANY TYPE OF ANAESTHETIC? .....

If I cannot be contacted, I give permission to the person in charge or his/her delegate, to permit the administration of blood for transfusion and / or anaesthetic.

SIGNED ..... DATE .....

If your child is prescribed medication during the season, it is your responsibility to advise the club.